Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2017	2017_597655_0013	013378-17	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Lancaster Long Term Care Residence
105 MILITARY ROAD NORTH P.O. BOX 429 LANCASTER ON K0C 1N0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MICHELLE EDWARDS (655), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 12, 13, 14, 17, 18, 19, 20, 21, 26 and 27, 2017.

The following Critical Incidents were inspected concurrently:
- Log #006274-17, related to an allegation of staff to resident neglect; and,
- Log #009821-17, related to a fall.

During the course of the inspection, the inspector(s) spoke with residents and families, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Registered Dietician (RD), the Nursing Consultant, and the Administrator.

During the course of the inspection, the inspectors also observed the provision of resident care and services, reviewed resident health care records, policies and procedures, and documentation related to bed system evaluations.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

Resident #005 was admitted to the home on a specified date with multiple diagnoses.

According to the resident’s health care record, resident #005 required the use of a positioning aide. The positioning aide was identified in the resident's care plan, which included specific direction related to it's use for resident #005.

On a specified date, resident #005 was found on the floor, having sustained an injury after a fall.

In an assessment that was completed on the same day, it was noted that resident #005's positioning aide was not provided to the resident as specified in the resident's plan of care at the time of the incident.

During an interview, PSW #119 indicated to Inspector #551 that on the day of resident #005's fall, the resident had been left alone while staff attended to another resident's care needs. According to PSW #119, the positioning aide was not provided to resident #005 as specified in the plan of care when staff left resident #005 at the time. PSW #119 was not aware, at the time of the incident, that the positioning aide was a safety requirement for resident #005.

At the time of resident #005's fall on a specified date, resident #005 was left unattended without a specific positioning aide, though the positioning aide was specified in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #022 as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director of the Ministry of Health and Long-Term Care under the Long-term Care Homes Act on a specified date, under O. Reg 79/10, s. 107 (3) (4) (Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident’s health status).

Resident #022 was admitted to the home on a specified date. According to the resident's health care record, resident #022 required the use of mobility aids for ambulation. In

addition, the resident was identified as being at a risk for falls.

In the resident's written plan of care, several falls prevention and related safety interventions were identified.

On a specified date, resident #022 was found on the floor, having sustained an injury after a fall.

During an interview, RN #118 indicated to Inspector #551 that he/she had assessed the resident after the fall on the specified date. According to the RN, one of the interventions identified in the resident's plan of care related to falls prevention and safety, had not been in place when resident #022 had the fall on the specified date.

When resident #022 fell on a specified date, a specific intervention was not in place as specified in the residents' plan of care.

The licensee failed to ensure that the care set out in resident #005's and resident #022's plan of care was provided to the residents as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for resident #005 and resident #022 is provided as specified in the the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident's bed system was evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used "as a best practice document".

The HC Guidance Document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (the cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

It is recognized in the HC Guidance Document that legacy beds have the potential for dimensional change over time through wear and tear or substitution of bed components. It is further indicated that facilities should ensure that bed rails and other components are maintained and replaced as needed; and that after such a change occurs, the resulting new bed systems continues to meet the recommendations of HC.

According to the HC Guidance Document, a bed system may require re-evaluation when there is reason to believe that a bed system component is worn (for example, the rails wobble or are loose). As indicated in the HC Guidance Document, a lateral shift and/or degree of play from a loosened bed rail is a factor which may increase the gap size in potential entrapment Zones 2 (under the rail, between supports), 3 (between the rail and the mattress), and 4 (under the rail at the ends of the rail).

It is also recommended in the HC Guidance document, that when a component of a bed system is changed or replaced (new bed rails or mattress, for example), the resulting new bed system is evaluated in accordance with the prevailing practices, outlined in the HC Guidance Document.

On July 12, 2017, Inspector #655 observed the bed system belonging to resident #012. At that time, two ¼ length bed rails were observed to be in the up position. From the foot of the bed, the left rail was observed to be loose. At the same time, the right rail was observed to be leaning outward, away from the bed system. On the same day and over the course of the inspection, six other bed systems were observed to have loose bed rails, including the bed rails on the bed systems belonging to resident #'s 011, 014, 010, 019, 007, and 009.

On July 12, 2017, Inspector #655 had informed the Administrator of the concern related to the observed prevalence of loose bed rails in the home. In response, the Administrator conducted an audit.

In conducting the audit, the Administrator observed all of the bed systems in the home and identified those bed systems which had one or more loose bed rails in place. The Administrator indicated to Inspector #655 that the results of the audit were provided to maintenance staff for verification and follow-up. A copy of the results of the bed audit were also provided to Inspector #655.

On review of the bed rail audit documentation, dated July 12, 2017, it was noted by Inspector #655 that a total of 30 bed systems (out of 61), or 49% of all bed systems, had been identified by the Administrator as having one or more loose bed rails in place at the time of the inspection, including the bed system belonging to resident #012 which the Administrator identified as having two loose bed rails in place at the time.

During an interview on July 20, 2017, the Administrator indicated to Inspector #655 that as a result of the audit, corrective actions had been taken in order to address the loose

bed rails on the bed system belonging to resident #012. From the foot of the bed, the right bed rail was tightened; while the left bed rail was removed and replaced with a new bed rail.

Inspector #655 reviewed the document, "Bed Entrapment Log"/"Master Bed-Mattress Audits" (the Log), provided to the Inspector by the Nursing Consultant on July 18, 2017.

According to the Log, the bed system belonging to resident #012 was last evaluated for entrapment risk in accordance with the methods outlined in the HC Guidance Document over one year ago. As a result of the bed system evaluation process (entrapment testing) which occurred over one year ago, resident #012's bed system was given a passing grade, as the potential zones of entrapment were determined to be within the prescribed dimensional limits at that time (Zones 1-4).

Inspector #655 was unable to locate any documentation to demonstrate that the bed system had been monitored for signs of wear and tear; or that it was re-evaluated any time since the entrapment testing that took place over a year ago, when components of the bed system were worn (i.e. loose rails). In addition, there was no documentation to demonstrate that the resulting new bed system was evaluated in accordance with the prevailing practices outlined in the HC Guidance Document after the left bed rail was replaced during the Inspection.

During an interview on July 27, 2017, the Administrator was unable to speak to whether the resulting new bed system belonging to resident #012 had been evaluated in accordance with the prevailing practices outlined in the HC Guidance Document after the left rail was replaced during the inspection. The Administrator was also unable to locate any documentation to demonstrate that it had.

Over the course of the inspection, it was also determined through record reviews and discussions with the Administrator, that a bed rail had also been replaced on the bed system belonging to resident #003.

According to the Log, the bed system belonging to resident #003 was last evaluated for entrapment risk in accordance with the methods outlined in the HC Guidance Document over one year ago. As a result of the bed system evaluation process which occurred over one year ago, resident #003's bed system was given a passing grade, as the potential zones of entrapment were determined to be within the prescribed dimensional limits at that time (Zones 1-4).

According to a Maintenance Request Form, one of the bed rails on the bed system belonging to resident #003 was removed and replaced with a new one on a specified date, because it was loose. Inspector #655 was unable to locate any documentation to demonstrate that the resulting new bed system was evaluated in accordance with the methods outlined in the HC Guidance Document.

Inspector #655 reviewed the policy titled "Bed Systems" (LTC-CA-ON-100-05-16, last revised July, 2016), provided to Inspector #655 by the Administrator on July 27, 2017. According to the licensee's "Bed System" policy, every bed system in the home is to be evaluated in accordance with the standards defined by Health Canada. In addition, each bed system is to be evaluated whenever any component of the bed system is changed – including: when a bed rail is replaced. In the "Bed Systems" policy, it is further stated that housekeeping staff, with each deep clean, and the PSW during linen changes, will inspect the mattress and pillow for wear and tear. On review of the policy, Inspector #655 was unable to identify any stated requirement for the monitoring of wear and tear of any other bed system components, such as bed rails.

During an interview on July 27, 2017, the Administrator indicated to Inspector #655 that it is expected that when any component of a bed system has been modified or replaced (including a bed rail), the resulting new bed system is evaluated in accordance with the prevailing practices. At the same time, the Administrator indicated to Inspector #655 that bed systems were also expected to be re-evaluated for risk of entrapment when there is reason to believe that a component such as a bed rail is worn (i.e. loose) and may present a risk to the resident.

On review of the Log, it was also noted by Inspector #655 that four of the six other bed systems observed by the Inspector to have loose bed rails (the bed systems belonging to resident #'s 011, 014, 010, and 007) were also last evaluated in accordance with the prevailing practices outlined in the HC Guidance Document over one year ago. According to a Maintenance Request Form, the bed system belonging to resident #010 was identified by a staff member as having a loose bed rail more than three months before the inspection.

Moreover, there was no indication that the bed systems identified as having one or more loose bed rails as a result of the July 12, 2017, audit conducted by the Administrator had been re-evaluated any time between July 12 and July 27, 2017 – a two week period. The cone and cylinder tool used for entrapment zone testing was observed to be in the home

at the time of the Inspection.

The licensee has failed to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that bed systems are evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident equipment, including bed rails and bed systems, are maintained in a safe condition and in a good state of repair.

On July 12 and July 13, 2017, Inspector #655 observed that the bed rail (s) on the bed systems belonging to resident #'s 011, 012, 014, 010, 019, 007, and 009, were loose - or, unsteady - in that the rail (s) shifted laterally in response to light pressure applied by the Inspector's grasp; and, in one case, the rail dropped slightly toward the ground. The identified bed rails were identified by the Inspector as posing a potential risk to residents

(i.e. if used as a transfer aid and/or entrapment risk related to potential dimensional changes associated with wear and tear).

On July 13, 2017, Inspector #655 also observed the mattress and/or mattress deck on the bed system belonging to resident #003 was uneven. At the same time, resident #003 described the bed system as being uncomfortable, and having a "lump". On observation of the bed system, the Inspector observed the "lump", located mid-way between the foot board and the middle of the bed. Resident #003 further indicated to Inspector #655 that the foot of the bed was always lower that then rest of the bed; and that it had been this way "forever". Resident #003 indicated to Inspector #655 that the concern had recently been reported to the staff member who assists the resident to bed at night; and was reported again to the Administrator on July 12, 2017. There was no indication that the mattress and/or mattress deck on the bed system belonging to resident #003 had been addressed or repaired over the course of the inspection - a two week period.

On July 12, 2017, Inspector #655 informed the Administrator of the concern related to the prevalence of loose bed rails in the home.

During an interview, PSW #110 indicated to Inspector #655 that staff use a log book to document any identified maintenance concerns and to communicate the concern to maintenance staff. According to PSW #110, this process is used for concerns identified related to resident equipment including bed systems and bed rails. PSW #110 indicated to Inspector #655 that maintenance staff is available in the home five days a week. PSW #110 explained to Inspector #655 that when the maintenance worker is away from the home, a maintenance issue such as a loose bed rail is normally not repaired until the maintenance staff returns to the home.

Inspector #655 reviewed the 2017 "Maintenance Request Forms" from the maintenance log described by PSW #110. It was noted that of the seven bed systems that were identified over the course of the inspection as having a loose bed rail, two had been reported at some time in writing in the maintenance log: those were the rails on the bed system belonging to resident #010 and #009. According to the maintenance log, the bed rails on these bed systems had been repaired on April 25, 2017, and July 4, 2017, respectively. According to the maintenance log then, the bed rail on the bed system belonging to resident #009 had been repaired just eight days before it was observed to be loose by Inspector #655 on July 12, 2017. There was no documentation located in the maintenance log book related to the condition of bed rails on any of the other bed systems observed to have loose bed rails; nor was there any documentation related to

the condition of resident #003's bed system as reported to a staff member by resident #003.

During an interview with the Administrator, Inspector #655 was provided with a copy of a bed rail audit that was conducted by the Administrator on July 12, 2017. The audit was conducted in response to the concern that was previously communicated (on July 12, 2017) to the Administrator by Inspector #655 regarding the prevalence of loose bed rails in the home. In conducting the audit, the Administrator observed all of the bed systems in the home and identified those bed systems which had one or more loose bed rails in place.The Administrator indicated to Inspector #655 that the results of the audit were provided to maintenance staff for verification and follow-up.

On review of the audit documentation, several bed systems were identified by the Administrator as having one or more loose bed rails in place at the time of the Inspection, including:
- the bed system belonging to resident #011, which was was identified by the Administrator as having one loose bed rail;
- the bed system belonging to resident #012, which was identified by the Administrator as having two loose bed rails;
- the bed system belonging to resident #014, which was identified by the Administrator as having one loose bed rail;
- the bed system belonging to resident #019, which was identified by the Administrator as having one loose bed rail; and,
- the bed system belonging to resident #009, which was identified by the Administrator as having two loose bed rails in place.

On review of the bed rail audit documentation, dated July 12, 2017, it was further noted by Inspector #655 that a total of 30 bed systems (out of 61), or 49% of all bed systems, had been identified by the Administrator as having one or more loose bed rails at the time of the inspection.

On July 17 and again on July 27, 2017, the bed systems belonging to resident #009 and #019 were observed by Inspector #655. At the time of each observation, each bed system was observed to still have a loose bed rail, unchanged from the Inspectors initial observations.

According to the Administrator, the bed rails on the bed system belonging to resident #019 could not be tightened by maintenance staff. Four other bed systems identified on

the bed rail audit dated July 12, 2017, to have two loose bed rails in place were also noted by the Administrator to have bed rails that could not be tightened by maintenance staff. These four bed systems were observed by Inspector #655 on July 27, 2017; at which time it was noted that three of the four bed systems still had loose bed rails.

Each of the bed systems observed by Inspector #655 were noted to have a label on the bed rail. On the label, each of the bed rails were identified as being a specific type of bed rail of a specific brand/manufacturer. According to the Administrator, all bed rails in use in the home were of the same type and brand.

Inspector #655 reviewed the "Installation Guide" for the identified type and brand of bed rail (in a section of the same manufacturer's bed manual) provided to the Inspector by the Administrator. According to this document, when installed, the identified type of rail should feel secure. In the guidance document, an annual maintenance check is recommended to ensure that the bed rails engage and lock appropriately; and so that any parts that are loose or show signs of wear are tightened, adjusted, or replaced.

During an interview, the Administrator indicated to Inspector #655 that maintenance is expected to complete a "maintenance audit" for all resident rooms twice a year. According to the Administrator and the maintenance audit template, the bi-annual maintenance audit would include an inspection of all bed rails to inspect the tightness of each rail and to ensure that the rail is secure to the bed and locks in place. As part of the same maintenance audit, all beds are expected to be inspected by maintenance twice a year to ensure that each bed system is functional and in good condition. The Administrator was unable to determine when the last maintenance audit had been completed; and was unable to provide any documentation to Inspector #655 that would demonstrate that a maintenance audit had been conducted.

The licensee has failed to ensure that resident equipment, including the bed rails in use by resident #009 and resident #019, and the bed system belonging to resident #003, are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all resident bed systems, including bed rails, are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

During the inspection, Inspector #655 observed RPN #101 administer resident #021's medications to the resident for the noon medication pass. Inspector #655 accompanied RPN #101 into resident #021's room to observe the medication administration, and subsequently accompanied RPN #101 for continued observation back to the medication cart. At that time, it was noted by Inspector #655 that the medication cart - which did not lock automatically but was required to be locked manually - was already unlocked. RPN #101 was able to open the medication cart drawers without using a key or access card. When RPN #101 was administering resident #021's medications in resident #021's room,

the medication cart was not within the RPN's eyesight. No medications were observed to have been left unattended on top of the medication cart by Inspector #655 during the medication pass for resident #021.

On July 18, 2017, Inspector #655 observed a medication cart of the same type (required to be manually locked) to be left unlocked and unattended at the nurses' station at 1244 hours. Several residents were in the area at the time of the observation. At 1251 hours, RPN #101 returned to the cart, and was observed to lock the medication cart at that time. The medication cart was left unlocked and unattended at the nurses' station for approximately six minutes. There were no medications observed to have been left unattended on top of the medication cart.

On July 26, 2017, Inspector #655 observed a medication cart to have been left unlocked and unattended at the nurses' station between 1327 and 1331 hours; and again between 1422 and 1425 hours, while registered staff were conducting medication passes. Inspector #655 was able to open the medication cart drawers during the observation period, while the medication cart was out of sight to registered nursing staff. Five residents were seated in the area of the nurses' station at the time of the observations. There were no medications observed to have been left unattended on top of the medication cart in either instance.

When RPN #109 returned to the nurses' station following the above-noted observations of July 26, 2017, Inspector #655 inquired about the unlocked medication cart. RPN #109 indicated to Inspector #655 that the medication carts are expected to be locked when unattended. RPN #109 was observed to lock the medication cart at that time.

At 1645 hours on the same day, July 26, 2017, Inspector #655 again observed two medication carts to be left unlocked and unattended. One medication cart was left at the nurses' station; while the second medication cart was left in the hallway next to the boiler room located near the dining room.

During an interview, RN #117 indicated to Inspector #655 that he/she had left the medication cart unlocked and unattended when he/she went to get some insulin.

During an interview on July 27, 2017, the Administrator indicated to Inspector #655 that medication carts are expected to be locked when they are not in the sight of the registered nursing staff.

In addition to the above observations, Inspector #655 also observed the Treatment Room door to be ajar and unlocked on July 12, 2017. Inspector #655 was able to enter the Treatment Room. Inside the room, there was an unlocked dressing supply cart. In the bottom drawer of the unlocked dressing supply cart, there were two tubs of prescription ointment belonging to resident #024.

During an interview on July 12, 2017, RPN #109 indicated to Inspector #655 that the Treatment Room is expected to be closed and locked when not in use. During an interview on July 27, 2017, the Administrator indicated the same.

The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas were medications are stored, including the Treatment Room and medication carts, are kept locked at all times when not in use, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

On July 12, 2017, Inspector #655 noted that the Resource Room door would not latch when it was closed, preventing the inspector from locking the door. The Resource Room is a non-residential area, where nursing and resident care equipment is stored. On July 12, 2017, Inspector #655 observed that the home's Crash Cart was stored in the Resource Room. There was no call bell. According to Maintenance staff #115, the door had not been fully closing due to a build-up of paint, and wear and tear of the surfaces of the door way. In the morning of July 27, 2017, the same door was observed to be ajar and unlocked. At the time of the observation on July 27, 2017, the Resource Room was not in use and was not observed to be supervised by staff.

On July 12, 2017, Inspector #655 observed the Treatment Room door to be ajar and unlocked. The room was not in use by staff at the time of the observation. Inspector #655 was able to enter the Treatment Room. Inside the room, there was an unlocked dressing supply cart. On an open shelving unit, there was a cleaning product in a jug labeled "Preempt CS20", with a descriptor that read "sterilant and high level disinfectant for medical devices and instruments". No call bell was observed in the Treatment Room.

During an interview on the same day, RPN #109 indicated to Inspector #655 that the Treatment Room door is expected to be kept closed and locked when it is not in use. RPN #109 was then observed to lock the Treatment Room door.

On July 12, 2017, Inspector #655 observed the Activity Storage room door to be closed, but unlocked. No call bell was observed in the Activity Storage room. Shortly thereafter, a staff member approached Inspector #655 and informed the Inspector that he/she had just accessed the Activity Storage room, and had left the door unlocked.

On July 26, 2017, Inspector #655 observed the Staff Room door to be open and unlocked. At the time of the observation, the staff room was not in use; and was not observed to be supervised by staff. Inspector #655 was able to enter the staff room. The staff room was comprised of three rooms: a kitchenette, bathroom, and lounge area. There was no call bell observed in the area of the kitchenette, nor in the staff lounge area. Inspector #655 closed the staff room door on exiting, engaging the locking mechanism.

During an interview on July 27, 2017, the Administrator identified the Resource Room, the Treatment Room, the Activity Storage room, and the Staff Room as being non-residential areas. The Administrator indicated to Inspector #655 that the Treatment

Room, Activity Storage room, and Staff Room doors are expected to be closed and locked when they are not in use. The Administrator indicated to Inspector #655, however, that while the Resource Room is intended for staff use, it is not normally locked. During the same interview, the Administrator confirmed that there was no call bell in the Resource Room.

The licensee has failed to ensure that that all doors leading to non-residential areas are locked when they are not being supervised by staff. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

On July 12, 2017, the Behaviour Support room door was observed to be open and unlocked. Inspector #655 was able to enter the Behaviour Support room, and was unable to locate a call bell inside. On July 26 and again on July 27, 2017, the same Behaviour Support room door was observed to be open and unlocked. At the time of each observation, the Behaviour Support room was not in use or being supervised by staff.

During an interview on July 27, 2017, PSW #114 indicated to Inspector #655 that residents are left unsupervised in the Behaviour Support room at times. PSW #114 explained to Inspector #655 that residents who are demonstrating behaviours are brought to the Behaviour Support room where a distraction is offered and/or the resident will engage in an activity such as listening to music.

During an interview on the same day, PSW #110 also indicated to Inspector #655 that the Behaviour Support room is used by residents who would not necessarily be supervised. PSW #110 explained to Inspector #655 that when a Behaviour Support staff member is present in the home, the Behaviour Support room door is regularly left open and unlocked. PSW #110 was unable to locate a call bell in the Behaviour Support room.

During an interview on July 27, 2017, the Administrator indicated to Inspector #655 that the Behaviour Support room was intended for resident use. After observing the Behaviour Support room, the Administrator confirmed that there was no call bell in the Behaviour Support room. According to the Administrator, in absence of the call bell system; there is a silver hand-bell available to residents who might require assistance while using the Behaviour Support room.

The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents. [s. 17. (1) (e)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated:

1. A change of five (5) per cent (%) of body weight, or more, over one (1) month.
2. A change of seven and a half (7.5) % of body weight, or more, over three (3) months.
3. A change of ten (10) % of body weight, or more, over six (6) months.
4. Any other weight change that compromises the resident's health status.

Resident #018 has resided in the home for a specified period of time. Resident #018 has multiple diagnoses, including a specified condition.

On a specified date, the Registered Dietician (RD) completed a consult due to unplanned weight loss of a specified amount which occurred over a one year period. A specified intervention was implemented.

After the specified intervention was implemented, resident #018's weight continued to decline month to month. Resident #018's weight declined by specified amounts month to month over a period of five months.

After the initiation of the above-noted intervention at the time of the above-noted RD consultation, no other actions were taken or outcomes evaluated despite the continued weight loss until four months later. Four months later, the corporate RD discontinued the intervention that had been implemented at the time of the initial RD consult and implemented a new intervention.

During the period of resident #018's weight loss, the RD consults that were requested by registered staff members due to resident #018's weight loss and suboptimal intake on three other specified dates were not completed.

During an interview, the current RD confirmed for Inspector #551 that, in a four month period, no actions were taken or outcomes evaluated, despite resident #018's continued weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Over the course of the inspection, it was determined through discussions with Nursing Consultant #112 and the Administrator that no medication incidents had occurred in the most recent full quarter, between April, 2017, and June, 2017; and that one medication incident had occurred in a specified month prior to the most recent full quarter.

During the inspection, the Administrator provided Inspector #655 with a copy of the Medication Incident Report (MIR) for the one incident which occurred on a specified date prior to most recent quarter. The incident occurred on a specified date, and was subsequently discovered a day later. The incident involved resident #024 and was described in the report as an error of omission. According to the MIR, RN #118 and a colleague discovered that a specified medication was remaining in resident #024's medication strip pack from the previous day. Documentation on the electronic Medication Administration Record of the same day indicated that the specified medication had been administered to resident #024, though it had not been.

During an interview, RN #118 indicated to Inspector #655 that on the specified date, resident #024 had missed one dose of a specified medication as a result of the error. At the same time, Inspector #655 reviewed the MIR for the above-described medication incident with RN #118. On review of the MIR, it was noted by Inspector #655 that there was no documentation related to the immediate actions taken to assess and maintain resident #024's health at the time of the incident, when resident #024 was found not to have received one dose of a specified medication.

During the interview, RN #118 indicated to Inspector #655 that when the error was discovered, immediate actions were taken to assess resident #024. RN #118 acknowledged that the immediate actions taken to assess and maintain resident #024's health, however, were not documented on the MIR. On review of resident #024's progress notes, RN #118 was also unable to locate any documentation related to the medication incident on the MIR.

During an interview, the Administrator was also unable to locate any documentation on the MIR related to the immediate actions taken to assess and maintain resident #024's health after the medication incident that occurred on a specified date. According to the Administrator, the MIR form that is supplied by the current pharmacy provider does not include a space for the nurse to document the immediate actions taken. The Administrator indicated to Inspector #655 that for this reason, the immediate actions taken would be documented in the residents' progress notes. The Administrator further

indicated to Inspector #655 that in that case, it is expected that the progress note would be printed and a copy would be attached to the MIR. During the same interview, the Administrator confirmed that no additional documentation accompanied the original MIR in this case.

The licensee failed to ensure that the medication incident involving resident #024 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

2. The licensee has failed to ensure that: a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary; and, (c) a written record is kept of everything required under clauses (a) and (b).

i. During the inspection, the Administrator provided Inspector #655 with a copy of the Medication Incident Report (MIR) for an incident which occurred on a specified date; and, was subsequently discovered one day later. The incident involved resident #024 and was described in the report as an error of omission. According to the MIR, on a specified date, RN #118 and a colleague discovered a specified medication remaining in resident #024's medication strip pack from the previous day. Documentation on the electronic Medication Administration Record of the same day indicated that the specified medication had been administered to resident #024, though it had not been.

During an interview, Inspector #655 reviewed the MIR with RN #118. It was noted that the section titled "Analysis of incident"; and, the section titled "Corrective Action Plan" were left blank, containing no documentation that would demonstrate that the incident had been reviewed or analyzed, and no indication as to whether corrective actions were required or taken.

During an interview on the same day, RN #118 indicated to Inspector #655 that normally the above-noted sections are completed by the Director of Care; and that in the absence of a Director of Care, they would be completed by Nursing Consultant #112. According to RN #118, Nursing Consultant #112 had not reviewed the medication incident report for the incident that occurred on a specified date.

When Inspector #655 spoke to Nursing Consultant #112, the Nursing Consultant was unable to speak to any medication incidents occurring in the home within the time frame of the identified incident.

During an interview, the Administrator also indicated that the medication incident which occurred on a specified date had not been reviewed or analyzed by the DOC or designate as of yet.

Over the course of the inspection, there was at no time any indication that the medication incident had been reviewed or analyzed; and no written record to indicate whether corrective actions were deemed to be necessary or taken.

ii. According to the most recent Medical Advisory Committee (MAC) meeting minutes, two medication incidents occurred in a specific quarter (a period of three months), or since the time of the last review.

One of the medication incidents was described as an error in administration, involving an unidentified resident who was given an extra dose of a specified medication in error. There were no additional details related to this incident contained in the MAC meeting minutes.

During interviews, the Administrator was unable to provide any additional details related to this incident. The Administrator was unable to locate a Medication Incident Report related to this incident; and was unable to locate a Medication Incident Response Report related to this incident. There was no record of the residents name or the date of the incident. There was no written record to indicate that the medication incident had been reviewed or analyzed; and no record of corrective actions taken. [s. 135. (2)]

3. The licensee has failed to ensure that: (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and, (c) a written record is kept of everything provided for in clause (a) and (b).

During an interview, Nursing Consultant #112 reviewed the licensee's process for the management of medication incidents with Inspector #655. According to Nursing Consultant #112, the nurse who discovers the error is responsible for completing a Medication Incident Report (MIR) – a form that is provided to the home by the pharmacy service provider. On completion of the MIR, the form is given to the Director of Care for review and analysis, at which time corrective actions would be taken as required and

documented on the MIR. The MIR form is also faxed to pharmacy for review. All medication incidents are then reviewed at the Medical Advisory Committee (MAC) meetings - and with the Medical Director then, on a quarterly basis. According to Nursing Consultant #112, the most recent MAC meeting would have included a review of medication incidents occurring between a specific quarter (a period of three months).

Inspector #655 was provided with a copy of the most recent MAC meeting minutes.

According to the MAC meeting minutes, two medication incidents had occurred during a specified three month period. In the minutes, one error was described as a pharmacy error in which a discontinued medication was not removed from a residents' medication strip package.

A document titled "Medication Incident Response Report" (MIRR) accompanied the MAC meeting minutes. The MIRR included a description of the above medication incident, which occurred on a specified date and did not reach the resident. On the MIRR, there was also documentation related to the analysis of the incident; and a record of the corrective actions taken. The documentation was incident-specific, and did not include any considerations related to the second error referred to in the MAC meeting minutes.

The second error was described in the MAC Meeting Minutes as an error involving an unidentified resident, in which the resident was given an extra dose of a specified medication in error. According to the minutes, there was no injury to the resident. There was no additional information contained within the MAC meeting minutes to demonstrate that this incident had otherwise been reviewed as part of the quarterly review process.

During interviews, the Administrator indicated to Inspector #655 that the Medication Incident Response Reports (MIRRs) are used for the purpose of the quarterly review of all medication incidents. Over the course of the inspection, the Administrator was unable to provide any additional documentation related to the second incident, as described above. In addition, the Administrator was unable to identify the resident involved in the incident; and was unable to demonstrate that a Medication Incident Report or Medication Incident Report Response had been completed for the error involving the unidentified resident who received an extra dose of a specified medication.

There was no written record to demonstrate that a quarterly review was undertaken of both medication incidents that had occurred in the home since the time of the last review. [s. 135. (3)]

Issued on this 19th day of October, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.